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ABSTRACT

This report highlights the major issues discussed during a 2-day workshop on Medicaid funding for community-based mental health services for children and youth with severe emotional disturbances. The report opens with a brief description of the service needs of children and youth with severe emotional disturbances and the system of care that can meet those needs. It examines the role Medicaid can play in helping to finance services and some of the barriers state mental health planners face in using Medicaid funds. It describes the overall process that states must follow in developing a coordinated network of mental health and other services, with the emphasis on building a close working relationship with Medicaid agency personnel. The report then focuses on specific options states can use to expand the range of Medicaid-funded services available to children with severe emotional disabilities and describes the experiences some states have had using these Medicaid options. Appendixes contain a workshop agenda, a list of participants, and a description of services for children and adolescents from "Operation Help: A Mental Health Advocate's Guide to Medicaid" (Chris Koyanagi). (16 references) (JDD)

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USING MEDICAID TO INCREASE FUNDING FOR HOME- AND COMMUNITY-BASED MENTAL HEALTH SERVICES FOR CHILDREN AND YOUTH WITH SEVERE EMOTIONAL DISTURBANCES

A REPORT ON A CASSP WORKSHOP
HELD ON SEPTEMBER 14 AND 15, 1988
IN BETHESDA, MARYLAND

CASSP Technical Assistance Center
Georgetown University Child Development Center

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A REPORT ON A CASSP WORKSHOP HELD ON SEPTEMBER 14 AND 15, 1988 IN BETHESDA, MARYLAND

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INTRODUCTION

The Child and Adolescent Service System Program (CASSP) was established in 1984 by the National Institute of Mental Health (NIMH) to support states in the development of a comprehensive, integrated network of community-based services for children and youth with severe emotional disturbances. Currently, CASSP provides grants to 40 states and local areas to foster interagency collaboration and coordination across many different service systems and funding sources.

Medicaid is a primary resource for state mental health planners to use in developing the service system needed by this population. But many states are not taking full advantage of Medicaid's mental health funding potential and, as a result, many children with severe emotional problems are going without the care they need.

To help states in their efforts to plan, develop, and finance a coordinated system of care, the CASSP Technical Assistance Center at the Georgetown University Child Development Center sponsored a workshop on September 14 and 15, 1988, on Medicaid funding for community-based mental health services for children and youth with severe emotional disturbances. The National Association of State Mental Health Program Directors co-sponsored the meeting.

Representatives of mental health and Medicaid agencies from 10 states met in general sessions to learn about options under Medicaid for financing home- and community-based mental health services and to hear about successful state efforts to use these options in their child mental health programs. The state delegations also met separately to develop their own strategies for improving Medicaid reimbursement for mental health services for children and youth with severe emotional disturbances. The workshop agenda is included as Appendix A and the meeting participants are listed in Appendix B.

This report highlights the major issues discussed during the two-day workshop. As background, the report opens with a brief description of the service needs of children and youth with severe emotional disturbances and the system of care that can meet those needs. The report also looks at the role Medicaid can play in helping to finance this system of services and at some of the barriers state mental health planners face in using Medicaid

funds for home- and community-based services for this population. The next section describes the overall process states must follow in developing a coordinated network of mental health and other services, with the emphasis on building a close working relationship with Medicaid agency personnel.

The following section of the report focuses on specific options states can use to expand the range of Medicaid-funded services available to children with severe emotional disabilities and then describes the experiences some states have had--as outlined by state representatives at the workshop--in using these Medicaid options. Finally, the report summarizes the strategies the state delegations developed, during their individual planning sessions, for increasing the use of Medicaid dollars to fund services for children with severe emotional disturbances in their states.[1]

An earlier publication of the CASSP TA Center provides an overview of the Medicaid program and highlights the features of particular importance to children and adolescents in need of sustained mental health intervention. This is Harriette Fox's *An Explanation of Medicaid and Its Role in Financing Treatment for Severely Emotionally Disturbed Children and Adolescents*. This technical report focuses on both Medicaid eligibility policy and coverage policy, comparing what is federally authorized under Medicaid to current Medicaid practices across states. A recent report by Judy Meltzer of the Center for the Study of Social Policy, *The Use of Medicaid to Support Community-Based Services to Children and Families*, reviews current state practices in using Medicaid to finance a wide array of home- and community-based services for children. When these two publications are read along with this report, the reader will be able to gain a thorough understanding of Medicaid and its potential for financing home- and community-based services for children and youth.

COORDINATED SYSTEM OF CARE

An estimated 3 million children, or about 5 percent of the population under 18 years of age, have serious and persistent emotional disturbances.[2] But children termed severely emotionally disturbed don't constitute a single diagnosis group, Lenore Behar, Ph.D., Special Assistant for Child and Family Services, North Carolina Division of Mental Health, Mental Retardation and Substance Abuse Services, told conference participants. Invariably these children have many other problems besides emotional ones.

Such a child, for example, could have a learning disability and a speech disorder, be pregnant, abuse alcohol and/or drugs, live in a foster home, as well as suffer from severe depression. For such a child with multiple and overlapping problems, there is no single treatment. While these children clearly need some type of mental health care, they also require an array of other services, such as special education, child welfare, health, vocational rehabilitation and juvenile justice services, Behar said.

Child mental health experts agree that the mental health system alone cannot meet the multiple and changing needs of severely disturbed youngsters. This population's needs can only be addressed through a comprehensive network of mental health and other essential services, provided by many different service agencies. In their monograph, *A System of Care for Severely Emotionally Disturbed Children and Youth*, Beth Stroul and Robert Friedman describe the framework of a model system, consisting of seven dimensions of services (see Figure 1 below). The first and most important component of the system is a continuum of mental health services, ranging in intensity from hospitalization and other residential treatment services to less restrictive home- and community-based care.[3] The other dimensions of the system are: social services, educational services, health services, vocational services, recreational services, and operational services.

The proposed system of care described by Stroul and Friedman is guided by two fundamental philosophies about the manner in which services should be provided to these children. First, the system of care is child-centered, with the type and mix of services being tailored to the individual needs of the child and his/her family. In the diagram below, the child and family are at the center of the seven interconnected service dimensions.

The second underlying philosophy is that the system is community-based, with services provided and managed at the community level. While institutional care may be indicated for some severely disturbed children at certain times, the focus should be on providing services in less restrictive, more natural surroundings. Studies have shown that home- and community-based services are often more appropriate and usually more cost-effective than residential treatment. For example, in many crisis situations, intensive, in-home treatment, combined with other home- and community-based services and case management, can keep the family intact while avoiding costly, long-term institutional care, Behar said.

SYSTEM OF CARE FRAMEWORK

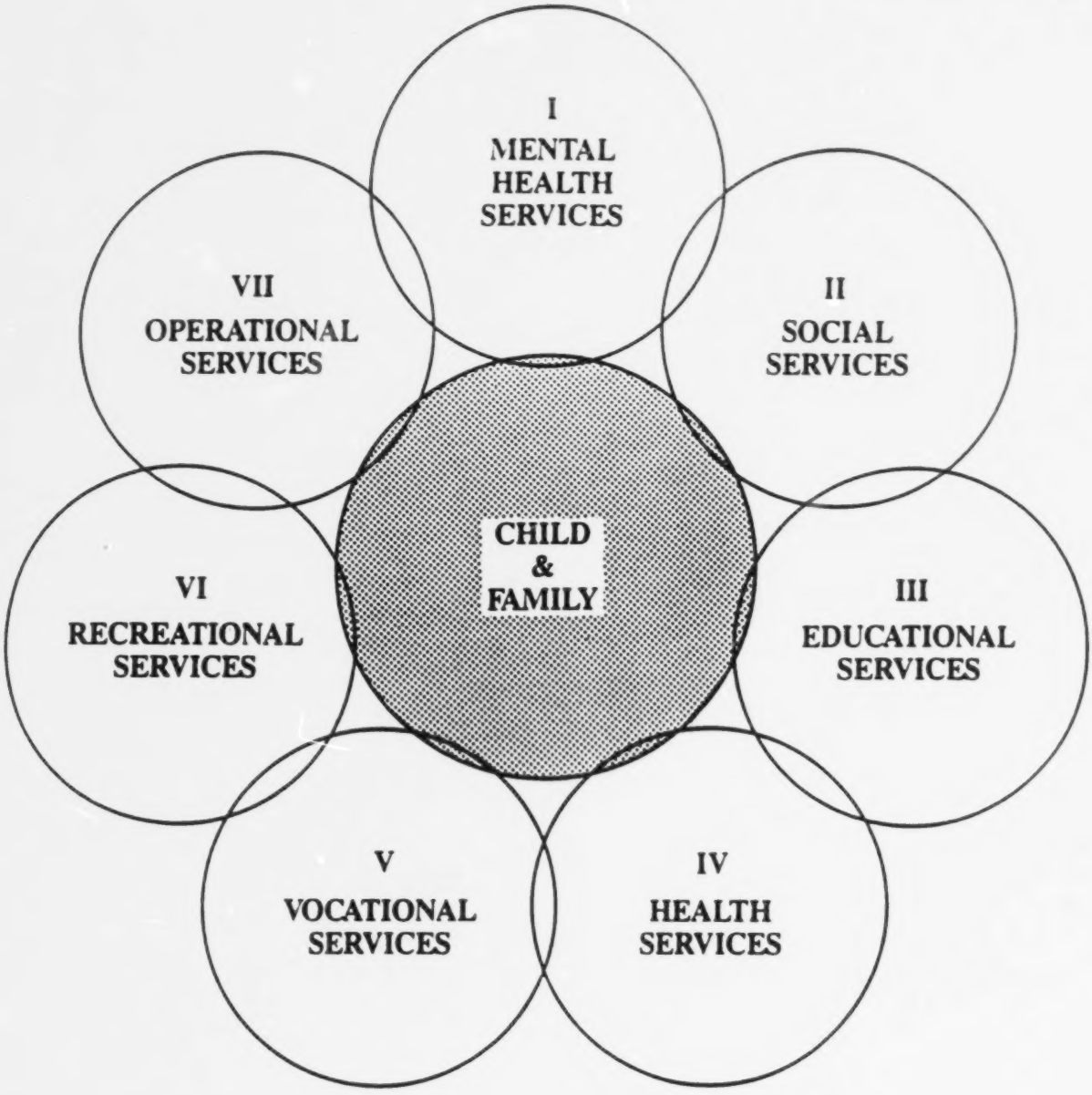

Figure 1

But an effective system of care not only incorporates a range of services, it also provides for the integration and efficient delivery of the many different service components. In Stroul and Friedman's model, the seven service dimensions are interrelated, the effectiveness of one component dependent on the availability and effectiveness of the others. A comprehensive, systematic approach to treatment requires close collaboration among the agencies responsible for the array of services. As Behar pointed out at the workshop, case management is also an essential part of this system of care, pulling together the different service components to meet the individual needs of the child.

Although a number of states--with the support of CASSP--have made progress in developing the range of services required by children and youth with severe emotional disturbances, unfortunately, very few have been successful in integrating the many service components into an efficient, cohesive system of care. Without interagency coordination, the individual service components lose their effectiveness, Stroul and Friedman said. "The consequence of these system deficiencies," they concluded, "is that treatment is often inadequate and fragmented."

MEDICAID FINANCING OF MENTAL HEALTH SERVICES

One of the biggest challenges for mental health planners in developing such systems of care is how to finance the range of services that children and youth with severe emotional disturbances need. Funds can come from many different sources, including Medicaid and other government entitlement programs; federal, state and local health, child welfare, social service, juvenile justice, education and vocational rehabilitation programs; state mental health appropriations; and private insurance. The funding sources are usually administered separately and have their own requirements for eligibility, benefits, reimbursement rates, and procedures for requesting support. Child mental health program directors must wend their way through this maze of rules and regulations to procure the dollars they need for the array of services.

Of the approximately 3 million children and adolescents with severe emotional disturbances, an estimated half receive care through public programs. And about half of these, or about 1 to 1.5 percent of a state's total child population, are low-income children eligible for Medicaid. While Medicaid alone cannot pay for the full continuum of therapeutic and support services needed by these children, it is an important resource for states to use in developing and financing a comprehensive, community-based system of care.

Under the Medicaid program states are reimbursed by the federal government for a certain proportion of the costs of providing services to low-income persons, in accordance with broad federal guidelines on eligibility and allowable benefits. The federal matching rate ranges from 50 percent to 80 percent, depending on the state's per capita income. Although the state's contribution is limited to the amount appropriated by the legislature, at the federal level Medicaid is an entitlement program, without an established cap on spending; the more a state is willing to devote to Medicaid, the more the federal government will contribute. On the other hand, the state legislature can establish--and in a number of states has done so--limits on the amount of state money available for certain Medicaid services. The Florida legislature, for example, places a specific dollar limit on Medicaid reimbursement for rehabilitation services. This is accomplished by including dollars for the match for "Medicaid rehabilitation services" in the mental health agency budget and not in the Medicaid agency budget.

In addition to sharing in the cost of providing services to Medicaid recipients, the federal government reimburses states for part of the cost of administering the program. The amount of the federal contribution depends on the nature of the administrative function, the training of the person who carries out that function, and on the level of medical expertise needed to perform that function. According to Health Care Financing Administration (HCFA) policy, 75 percent funding is available for administrative activities performed by "skilled professional medical personnel" that require "professional medical knowledge and skills," while other administrative functions that don't require professional medical expertise are reimbursed at a rate of 50 percent.

Complex Regulations

But before state mental health planners can capitalize on the financial opportunity afforded by Medicaid, they must overcome some problems inherent in the program. The first task is to decipher the many complexities of Medicaid legislation and regulations.[4] Although state Medicaid programs must conform to one set of broad federal rules, states have considerable license in deciding who is eligible, what services are covered, and how the program is administered. And the federal policy on allowable program expenditures is often interpreted differently by each of the ten regional offices of the Health Care Financing Administration. The result is a medley of 51 different Medicaid programs, with varying eligibility, coverage and administrative requirements.

- Eligibility. In terms of eligibility, there are three categories of people who can receive Medicaid assistance. The first group is the mandatory categorically needy, which includes children receiving or eligible to receive cash assistance under the Aid to Families with Dependent Children (AFDC), foster care and adoption assistance, or the Supplemental Security Income (SSI) programs. Also included in this group are all "qualified" children up to age seven whose family incomes and resources fall below the state AFDC payment level.

  Under the optional medically needy program, states may extend coverage to individuals who meet the categorical but not the financial eligibility criteria if their incomes don't exceed 133 1/3 percent of the state AFDC payment level.

  A new optional eligibility group, added in 1987, consists of all pregnant women, infants up to age one, and all children incrementally up to age eight, whose family incomes are above a state's AFDC income criteria but not above 100 percent of the federal poverty line. In addition, effective July 1988, states have the option of extending eligibility to pregnant women and to infants up to age one in families with incomes up to 185 percent of the federal poverty line.

  Because eligibility is linked to welfare and because the welfare payment level in many states is far beneath the federal poverty line, many poor children (especially children over seven years of age), remain excluded from coverage under Medicaid.

- Benefits. Under federal Medicaid rules, states must offer all eligible categorically needy persons certain mandatory services: inpatient and outpatient hospital services, physicians' services, rural health clinic services, laboratory and x-ray services, family planning services, home health care, skilled nursing facility care for adults, and early and periodic screening, diagnosis and treatment services (EPSDT) services for children. Medicaid legislation also authorizes states to include certain optional benefits, including prescription drugs, prosthetic devices and eye glasses; clinic services; home health care for children; rehabilitation services; private duty nursing; physical, speech and occupational therapy; other practitioners' services (such as psychologists); inpatient psychiatric facility services for children; intermediate care facilities for the mentally retarded; and most recently, case management services.

The benefits provided under the program are spelled out in the state Medicaid plan. But whether the covered services are mandatory or optional, states have wide leeway in defining the nature of the service and in determining its amount, duration and scope. States wanting to expand the range of community-based services available to severely disturbed children, for example, could specify in their state plans that the services of psychologists and social workers are covered. On the other hand, states could establish certain coverage restrictions, such as limiting the number of days, that have the effect of limiting the availability of needed services.

HCFA regulations do require, however, that once a state's coverage policy is established in the state Medicaid plan, all services--except special home- and community-based service waivers, targeted case management services, and treatment services under EPSDT--must be available uniformly to all Medicaid recipients in the state and in equal amount, duration and scope to all categorically needy eligibles. These provisions are known as the requirements for statewidedness and comparability.

- Reimbursement Rates. In addition to different eligibility criteria and coverage provisions, provider reimbursement rates vary among the states. Some providers may choose not to participate in Medicaid because the state's payment rate is too low; as a result many Medicaid-eligible children may be deprived of needed mental health care, even if the services are covered in the state Medicaid plan.

Philosophical Differences

Another barrier states face in using Medicaid to finance community-based mental health services for these children is the sometimes adversarial relationship between the state mental health agency and the Medicaid program. Alternatively, even when state agencies work together well, there may be conflicts between the state and HCFA. Part of the tension may stem from basic philosophical differences about health care delivery in general and the government's role in financing health care.

State mental health planners are often stymied in their efforts to develop and expand community-based services with fixed funds because of the Medicaid program's longstanding institutional bias. Medicaid does provide funding for certain types of noninstitutional care, but historically the financial incentives in Medicaid are skewed toward the use of inpatient

hospital services over less expensive outpatient care and home- and community-based services. In recent years Congress has amended the Medicaid legislation to permit states to expand coverage of home- and community-based services. But first state and regional Medicaid personnel must be convinced of the appropriateness and cost-effectiveness of noninstitutional care.

In addition, Medicaid, originally designed to cover the costs of "medical services" for the poor, has traditionally leaned toward a "medical model" in defining allowable services and providers. As a result, Medicaid's focus has been on hospital inpatient care, physicians' services, and medical supervision. The issue for state mental health planners is how to define medical services so as to include the use of nonmedical support services and nonphysician practitioners. Although Congress has more recently allowed states to cover certain nonmedical services as an option, HCFA personnel may be philosophically opposed to including such services in a Medicaid state plan.

Perhaps the biggest source of controversy between the two programs is the question of cost control versus expansion of services. Child mental health advocates, concerned with critical gaps in coverage for severely emotionally disturbed youth, are looking to Medicaid to help fund additional services to meet this population's needs. Advocates for other population groups, however, are also seeking a share of limited Medicaid funds. For Medicaid officials, then, the issue is how to distribute the fixed amount of state match funds among these many competing service priorities.

COOPERATION IS THE KEY ELEMENT IN THE SYSTEM DEVELOPMENT PROCESS

If progress is going to be made in meeting the multiple needs of children and youth with serious emotional disturbances, state child mental health staff and Medicaid agency personnel must work together to develop a system of comprehensive, community-based services. But, as emphasized in the Stroul and Friedman monograph, coordination and collaboration among all the diverse state and local agencies are essential during every stage of the system development process. The process starts with the earliest planning efforts, continues with the development of a state mental health plan--including strategies for financing the services in the plan--and culminates in the implementation of programs to serve the needs of this population.

State Mental Health Plan

While devising a strategy for financing the range of services is a critical part of the process, state mental health planners must first draw up a blueprint of the service system they envision for children with severe emotional disturbances. "Do your program thinking before your funding thinking," one workshop participant suggested.

In fact, states are required to develop comprehensive mental health plans for persons with severe, disabling mental illnesses, including children, under the Mental Health Planning Act of 1986 (PL 99-660). Each state must submit a plan to NIMH by January 10, 1989, with an update by October 1, 1989, and further refinements a year later. A state's failure to develop a plan meeting federal review criteria will result in a reduction in its alcohol, drug abuse and mental health service block grant. The major elements of an acceptable plan are outlined in "Toward a Model Plan for a Comprehensive, Community-Based Mental Health System," a technical assistance document issued by NIMH in October 1987.

State Medicaid Plan Amendments

Once the state mental health agency has determined what specific services it wants to provide and which ones can receive financial support from Medicaid, it may work with state Medicaid staff to seek an amendment to the state Medicaid Plan. This plan is basically a contract between the state and HCFA, describing what services will be provided, who will be covered, and how the program will operate.

The procedures for amending the state Medicaid plan vary from state to state. Although a few states may require legislative approval of any change in the plan, for most states the process is fairly easy, according to Richard Jensen, Senior Staff Associate at the National Governors' Association. "If a plan is not being changed," he said, "it's because of inertia in the state." While some participants agreed with Jensen's characterizations, others noted throughout the conference that the plan amendment process is protracted and difficult.

The usual course is for the HCFA regional office to approve changes in the plan. If, however, the proposed amendment isn't approved at the regional office, then there is an automatic appeal to HCFA's central office in Baltimore. The state may then, if necessary, appeal to the federal court.

One workshop speaker, Richard Tully, Assistant Deputy Director for Program Support, Ohio Department of Mental Health, cautioned state mental health agency staff to be prepared to defend the state's entire program when requesting a plan amendment. "HCFA is puzzled about mental health services," he said; "a proposed plan amendment gives Medicaid an opportunity to scrutinize the state's entire Medicaid mental health system."

The way to minimize problems during the plan approval process is for state mental health personnel to develop an ongoing, working relationship with people in the state Medicaid agency and to help them understand program objectives. Medicaid personnel need to recognize that the two programs have shared objectives for a common population. "Don't just go there when you need money," he said.

State Government Structure

In most states the Medicaid agency and the mental health agency are in two separate components of state government, often with no organizational linkage between them. Staff in the two different agencies have little opportunity to communicate on a regular basis and therefore are often in the dark about each other's programs. Usually the mental health agency must first develop its plans for mental health services and then go to the Medicaid office to request the funds to help pay for the planned services.

But the governmental structure in some states links the Medicaid and mental health agencies, as well as other related offices, under a common umbrella agency or department. Such an arrangement can facilitate an ongoing relationship between the two and provide a framework for joint state planning. In Pennsylvania, for example, the Public Welfare Department is composed of six separate agencies: Mental Health, Mental Retardation, Medicaid, Income Maintenance, Social Programs, and Children, Youth, and Family Services. The state's philosophy, explained David Feinberg, Deputy Secretary for Mental Health, is for each agency to administer that part of the Medicaid program on which it has the most expertise, developing its own policy, regulations, budget, state plan, and waiver programs. The state Medicaid agency provides consultation to the other offices and processes Medicaid claims.

Because Pennsylvania's Office of Mental Health has control over the Medicaid funds for mental health services, program planning goes hand-in-hand with budget development. According to David Smith, a special assistant in the mental health office, one of the objectives of his job is to

maximize the use of federal funds to support community-based mental health services.

Similarly, in Vermont the Department of Mental Health makes decisions about the management of the Medicaid mental health program, while the Department of Social Welfare handles Medicaid eligibility and administrative issues at the state level, said John Pierce, Director of Contract and Program Development, Department of Mental Health; both departments are components of the Agency for Human Services. The mental health staff writes the state plan and works directly with HCFA on plan amendments; budgets the Medicaid match and goes to the legislature to defend it; and monitors and evaluates the quality and utilization of Medicaid mental health services, Pierce told the conference participants.

MAXIMIZING MEDICAID DOLLARS TO SUPPORT MENTAL HEALTH SERVICES FOR CHILDREN WITH SEVERE EMOTIONAL DISTURBANCES

In the last few years more and more state mental health agencies have been making the effort to learn about the intricacies of Medicaid policy and to promote a closer working relationship with Medicaid. They are using the many options provided by Medicaid to fund a range of community-based services for children and youth with severe emotional disturbances.

As Harriette Fox, President, Fox Health Policy Consultants, pointed out to the state delegates at the workshop, states can piece together the flexible benefits authorized by Medicaid so as "to cover many, if not most, of the mental health interventions that are part of a continuum of care for these vulnerable children." Several conference sessions focused on these different benefits, with Fox and other Medicaid experts describing each provision and panels of state representatives reporting on their experience in using the option.[5]

Fox urged participants to pay close attention to what the state delegates would say about their programs' service definitions, medical necessity criteria and provider participation standards. "These are the phrases in the Medicaid world," she said, "that really make the difference between whether a service can be reimbursed for the target population or whether it cannot."

The Medicaid service benefits discussed included: clinic services; rehabilitation services; personal care services; home- and community-based waivers; early and periodic screening, diagnosis and treatment (EPSDT)

services; and case management. In addition, one agenda session included a discussion of Medicaid coverage of special education "related" services for handicapped children, as recently clarified by federal statute.

Clinic Services

Clinic services are defined as "any preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services" furnished to an outpatient by or under the direction of a physician or dentist in a facility that is "not a hospital but is organized and operated to provide medical care to outpatients." Although the services may not be provided in a recipient's home or in another location separate from the clinic facility, they may be delivered at a recognized satellite site, such as a school, residential treatment facility, or mobile van, Fox said. In such off-site locations, the physician or dentist would not have to be present at the time the service is delivered, but would have to supervise treatment.

All but three states provide clinic service benefits, Fox reported, but they differ widely in the categories of free-standing clinics covered and in the types of services that may be reimbursed in each category of clinic. The important thing to remember when defining covered services and allowable providers, Fox told the audience, is that the definitions should reflect the program needs of the target population.

While, strictly speaking, clinic services may not include home visits, Fox suggested there are ways to cover home visits within the confines of the law. She pointed to the example of Massachusetts' early intervention program, which authorizes home visits by licensed psychologists and psychiatric social workers associated with a clinic. This coverage was accomplished by joining the clinic services option with the option of covering the services of "other licensed practitioners," who may provide their services in any setting.

Nevertheless, the clinic service benefit's restrictions on setting and medical supervision have been a problem for some states. Florida, for example, operated a clinic service program from 1982 to 1984, but abandoned it in favor of the rehabilitation service option because the restrictions hindered the state in implementing its policy of community-based mental health services, Devon Hardy, Program Administrator for the Alcohol Drug Abuse and Mental Health Children's Program, Florida Department of Health Rehabilitative Services, said (see below under rehabilitation services).

Although concerned about the setting restrictions in the clinic option, Michigan's Department of Mental Health (DMH) has had a clinic service benefit since 1985. Over the last few years this program has provided the most Medicaid reimbursement for the non-institutional mental health system, Marilyn Walden, Director, Federal Entitlements and Standards Division, Michigan Department of Mental Health, said. One reason for the program's success is the range of services which each of the providers must furnish, she said. To ensure competence of participating providers, each must be approved by the DMH. The list of covered services includes testing, diagnosis and evaluation, psychiatric assessment, periodic review of treatment and medication, and interdisciplinary treatment planning. Mental health interventions include individual, group and family therapy and crisis intervention treatment. In addition, the program covers speech, hearing and language services; health services; physical therapy; occupational therapy; and transportation. Various day programs are also included, some in combination with educational programs. While the latter are good clinically, Walden said, they can be an accounting "headache" because of the difficulty of distinguishing between mental health services and educational services.

Rehabilitation Services

The definition of rehabilitation services includes "any medical or remedial services recommended by a physician or other licensed practitioner...for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level."

As Fox noted in her presentation, the rehabilitation services benefit offers states far more flexibility than the clinic services option in financing care for children and adolescents with severe emotional disturbances. The service may be delivered in any setting, and may be provided by a professional or by any specially trained aide or paraprofessional staff, she said. A wide variety of services could be covered, such as individual, family or group therapy; social rehabilitation; crisis intervention; and occupational, physical or speech therapy.

Although this option has been widely used to finance mental health rehabilitation services for adults, only recently have states been interested in using it for children with serious emotional problems. Florida, however, has been operating a rehabilitation program for Medicaid-eligible children and adults since 1984, after switching from the clinic services benefit. The rehabilitation option has given Florida flexibility in defining

the type of services covered, the service delivery settings, and the allowable providers, explained Devon Hardy.

The Florida state plan provides for reimbursement for four categories of services, Hardy told the participants: office visits, admissions and medical services; evaluation and testing; counseling, including various kinds of psychotherapy, vocational rehabilitation counseling, and social rehabilitation services; and day treatment. The services are to be provided in accordance with an individual treatment plan, which outlines the diagnosis, treatment objectives and the services to be provided.

Florida's program has no restrictions on the treatment site; Medicaid-eligible children may receive services at many different locations, such as clinics, home, school, day treatment sites, and foster homes. A wide array of provider types are allowed, including community mental health centers, clinics, and free-standing alcohol and substance abuse treatment centers. In Florida approximately 85 providers are under contract to furnish rehabilitation services.

Florida's rehabilitation services program for persons under 21 years of age has grown substantially over the four years of its operation, from about $1.6 million in Medicaid expenditures in 1984 to about $2.7 million in fiscal 1988. Under the clinic option, only $600,000 was spent for this population, Hardy said. Medicaid spending for rehabilitation services for both adults and children is expected to be around $19 million in FY 1989, approximately 1 percent of the total projected federal-state Medicaid expenditures of $2 billion, he said.

However, Hardy warned that this increase in Medicaid reimbursement for rehabilitation services for children and youth was offset in Florida by a corresponding decrease in the budget for community mental health centers who provide most of these rehabilitation services. Now that the state is billing Medicaid for community-based mental health services by using the rehabilitation option, the amount of federal dollars to the state has increased while direct state dollars budgeted for these services has decreased by an equivalent amount. This has not resulted in the expenditure of additional funds at the service delivery level.

Personal Care Services

The personal care service option is intended to help Medicaid eligibles with the activities of daily living at home. Under Medicaid regulations, personal care services are defined as services provided in a recipient's home, which

are "prescribed by a physician in accordance with a recipient's plan of treatment and provided by an individual who is 1) qualified to provide the service; 2) supervised by a registered nurse; and 3) not a member of the recipient's family."

While personal care services are usually thought of as home-based care for the frail, elderly or mentally retarded adults, Fox said, the benefit is broadly defined and can be used creatively by states to finance a variety of nonskilled, hands-on and household services for families with children and youth with severe emotional disturbances. These types of services could constitute a form of respite care, enabling children with serious emotional problems to remain in their own homes.

Michigan is one of the few states that covers mentally ill children under its Medicaid personal care services program. Total Medicaid expenditures in Michigan for the program are around $100 million, with about $500,000 directed to these children. Covered services include assistance or guidance in daily activities, such as eating/feeding, toileting, bathing and grooming; housekeeping chores, such as personal laundry and meal preparation; and assisting with self-administered medication. Three types of settings are covered: adult recipients' own homes; general foster care homes; and mental health special contract homes, which include foster homes for 275 mentally ill youngsters.

But June 1988 proposed HCFA rules on personal care would virtually wipe out the state's mental health personal care program, including services for children, Ron Eggleston, Manager, Institutional and Alternatives of Long Term Care Policy Section, Michigan Department of Social Services, said. One provision in the proposal would prohibit reimbursement for personal care services provided in a facility with four or more beds; another provision of concern to mental health programs would require onsite supervision of personal care providers.

Home- and Community-Based Waivers

Home- and community-based waivers--referred to as 2176 waivers after Section 2176 of the Omnibus Budget Reconciliation Act of 1981--allow states to finance a variety of noninstitutional services for a specified target group of individuals who otherwise would need expensive institutional care. There are two types of waivers: regular and model. They differ mainly in the number of people served and in the income and eligibility criteria that must be waived.

Under both waiver programs, states can choose to target chronically mentally ill Medicaid participants, or even just severely disturbed children and adolescents who would otherwise be institutionalized. For selected groups, states can choose to provide regular Medicaid services not covered in the state plan and other benefits not permitted under Medicaid law, Fox said. For these children the covered services could include, for example, partial hospitalization services, psychosocial rehabilitation services, clinic services, optional case management services, and, if specially approved by HCFA, mental health services provided in residential treatment facilities.

But Fox warned that the waiver process is tedious and prolonged and that for many states it may not be feasible or necessary. To receive waiver approval, a state must provide documentation to HCFA that the home- and community-based services proposed for the target population will cost Medicaid the same or less than institutional care for the identical population.

While a few states received waivers to serve seriously disturbed children and youth, only one state--Vermont--still operates a waiver program. John Pierce, Director of Contract and Program Development for the State's Department of Mental Health, was on hand to describe Vermont's successful program.

Vermont's waiver has resulted in a significant reduction in child and adolescent admissions to psychiatric hospitals and an increase in the use of noninstitutional, community-based alternatives. In 1981, before the waiver, almost 100 seriously disturbed children were served in psychiatric facilities; in 1987, under the waiver program, the number of institutionalized children dropped to 12, while the number served in a home or community setting was 67.

The program covers many of the services in the continuum of care needed by these children, Pierce said. The services fall into three general categories: intensive home- and family-based services; therapeutic and professional foster care; and group residential treatment. Vocational services, education, room and board, and inpatient services are not included.

While the program has worked well in Vermont, not all states should consider seeking a 2176 waiver, Pierce suggested. For example, a waiver doesn't really make sense for a state that is not already spending Medicaid money for inpatient care for these children; the waiver basically shifts funding from the institutional setting to the community, he explained, and

does not usually result in any new dollars. In addition, a firm commitment to the concept of community-based care must already exist in the state to support the waiver request. A state must also have access to population, cost and utilization data in order to document its request and to monitor the program once approved. And finally, he said, it is essential to have some type of cost containment and utilization control (gate-keeping) mechanism that can reduce institutional care and at the same time increase the use of community services.

In terms of the waiver process, Pierce agreed that the approval of an initial request or renewal requires substantial time and energy. But once the program is underway, "it is relatively streamlined to administer," he said. HCFA just recently renewed Vermont's waiver for another five years.

Early and Periodic Screening, Diagnosis and Treatment

Enacted by Congress in 1967, the Early and Periodic Screening, Diagnosis and Treatment program is intended to ensure that all Medicaid-eligible children under the age of 21 have access to and receive a broad range of primary and preventive health services. The law requires states to provide screening and diagnostic services to Medicaid children in order to identify "physical or mental defects" and then to provide treatment to correct or improve any defects or conditions found.

The statute further requires states to inform the families of Medicaid children about the availability of EPSDT services, to help recipients use the services, and to follow up to make sure that the children receive the necessary services.

Some components of a state's EPSDT program, such as the screening services, must conform to certain minimum requirements, but in other areas states are relatively free to design their own programs. Federal regulations issued in 1984 require states to offer a detailed, comprehensive health examination, including a health and developmental history, and unclothed physical examination; appropriate vision, hearing and lab tests; and appropriate immunizations. Dental examination by direct referral to a dentist and dental care to correct any problems must also be included. The number of screening visits a child should receive at each stage of life are to be indicated in established periodicity schedules, which must adhere to "reasonable standards of medical and dental practice." As for diagnosis and treatment of conditions found during the screening process, states must provide all services included in the state Medicaid plan, appropriate

additional immunizations, and certain other dental, vision and hearing services, including eyeglasses and hearing aids.

In addition, the EPSDT regulations give states the option of providing any other diagnostic and treatment services authorized under Medicaid law, "even if it is not available to all Medicaid-eligible individuals or it is provided in a lesser amount, duration and scope to others." Further, as Kay Johnson, Senior Health Specialist at the Children's Defense Fund said, using this option to enhance child health benefits, states could add a range of diagnostic and treatment services commonly needed by children with severe emotional disturbances. States also could structure a program which allowed a child to enter the EPDST system at the diagnostic and treatment phase, as is now done in the area of dental care. Similar to dental care, states may want to require prior authorization for certain high cost diagnostic or treatment services. Subsequent to the request for services covered only under EPSDT, screening examination would be due according to the state's established EPSDT periodicity schedule. The option for care following a partial screen is an alternative in many states. Following a partial screen, the child would be due for all other age appropriate elements of the screen.

The importance of this expanded treatment option in developing community-based services for children and youth with severe emotional disturbances was stressed repeatedly throughout the two-day conference. In her overview of the EPSDT program, Johnson emphasized that this provision enables a state to provide certain services, such as rehabilitation services or unlimited teen prenatal care, to Medicaid children only, when budget constraints prevent the state from offering the same services to the total Medicaid population. But she expressed concern that because recent legislative expansion of Medicaid eligibility does not cover children over seven years of age, many older youngsters with potentially serious health problems are not being identified or receiving treatment.

Besides providing the screening, diagnosis and treatment services, states have a number of other obligations, such as informing eligible families about the program, assisting families with appointment scheduling and transportation, assisting in the identification of free or reduced-cost care when needed services are not included in the state's Medicaid plan, and developing agreements with other agencies to ensure an adequate supply of EPSDT providers.

Case management is an important part of an EPSDT program. As HCFA noted in an April 1988 transmittal to state Medicaid agencies, "Case

management provides the difference between a fragmented program in which examination, diagnosis, treatment, and other functions are performed in isolation from each other, and a comprehensive program based on the concept of getting children into the existing 'mainstream' system of health care delivery." An EPSDT case manager's responsibilities include collecting information on a child's health needs, making and following up on referrals for further diagnosis and treatment, maintaining a child's health history, and "activating the examination/diagnosis/treatment 'loop.'"

But for the most part states are not making full use of the flexibility and the funding potential of the EPSDT program to serve children with severe emotional disturbances. For one thing, states generally view EPSDT as a preventive health program, Fox said in her monograph on Medicaid, and tend to focus on the screening process. Few states have effective case management systems to ensure that children identified in the screening process are receiving the diagnostic and treatment services they need.

And most states are not taking advantage of the expanded benefit option to provide additional mental health services to this population. Another problem noted by Johnson is the failure of many state Medicaid agencies to fully inform families about the value of EPSDT; as a result, only 25 to 30 percent of eligible children ever receive the benefits available under the program.

Johnson concluded her presentation by recommending strategies for improving state EPSDT programs for severely disturbed children. First, states need to enhance their periodicity schedules to bring them into line with standards of practice established by the American Academy of Pediatrics. States should also amend their state Medicaid plans to include discretionary benefits for the EPSDT children, improve their outreach efforts, and increase their efforts to coordinate with other service programs.

Case Management Services

As North Carolina's Behar stressed at the beginning of the workshop, case management is an important component of the system of services needed by children with severe emotional disturbances; it is "the most essential unifying factor in service delivery," she says. The case manager pulls together a variety of services from many different sources to meet the multiple and changing needs of each child and his/her family.

Under the 1986 Consolidated Omnibus Budget Reconciliation Act (COBRA), states are authorized to provide case management to help Medicaid eligibles "gain access to needed medical, social, educational and other services." Case management has usually been used by third-party payers as a cost-containment mechanism that restricts reimbursement for care to the services of cost-effective providers, Fox pointed out in her monograph. But as a Medicaid option, case management is intended to ensure that Medicaid eligibles receive the full range of services they need.

States have wide flexibility in establishing case management programs. Like the 2176 waiver option but in contrast to the other Medicaid services, the case management benefit may be targeted to specific high-risk geographic areas within the state and/or population groups, such as mentally ill persons or even just children with severe emotional disturbances; the statewidedness and comparability requirements don't apply under the case management option. The only restrictions are that states must define in their Medicaid plans the case management services to be provided, the population groups and geographic areas to be served, and the educational and professional qualifications of the providers. Under the initial Medicaid policy, clients are free to select their own case managers; but a provision added later allows states to limit provider freedom of choice for two population groups: the chronically mentally ill and the developmentally delayed.

Joanne Griesbach, President of Wisconsin Family Ties, who moderated the case management session, described the role of case management from the perspective of a parent of an emotionally-disturbed child. Parents of emotionally disabled children lack knowledge about the service delivery system and they lack control over that system, as well as over their own children, she said. The case manager is the family's ally and advocate, someone who understands what the child and his/her family needs and knows how to secure the services needed from myriad agencies and funding sources. "Case management should be available to everyone in the public mental health system," she said.

But only a few states have developed plans for case management services that cover children and adolescents with severe emotional disturbances. Georgia's case management program, in operation since October 1987, targets only the most seriously emotionally disabled people, including children, in six areas of the state. The program would apply to an emotionally disturbed child or youth who has been discharged from a hospital two or more times in the previous year or who is living in a community residential treatment facility supported by the Department of

Human Resources (DHR). Although several hundred children with severe emotional disturbances qualify for case management, less than 25 are now receiving services, according to Jerry Garber, federal liaison in DHR's Division of Mental Health, Mental Retardation and Substance Abuse. The division's child and adolescent services program is working with community agencies to educate the staff on the case management benefit and to encourage them to refer eligible clients for case management services.

Michigan's Medicaid case management program targets four population groups, one of which consists of persons--including children--having a primary diagnosis of either mental illness or developmental disability. Unlike Georgia, Michigan provides case management services throughout the entire state. To receive case management services, an individual must have a documented need for access to a range of mental health services and a documented inability to gain access independently to needed services. The person may live in his/her own home, another household, or a supervised residential setting.

As defined in the Michigan state plan, case management services include: an assessment of a person's assets, deficits and needs; the development of a written case management service plan; the linking/coordination of services through negotiation and referrals to providers; periodic reassessment and follow-up of the client's status and needs; and continuous monitoring of services. Providers of mental health case management services to this target group must meet the qualifications for Medicaid enrollment as mental health clinic services providers.

If case management is billed as a medical service, Medicaid reimburses the state at its regular match rate. But a state may find it more advantageous to claim case management as an administrative activity instead of a service, Michigan's Ron Eggleston told the workshop participants. A state could qualify for the 75 percent match rate for medically-related administrative functions if it can show a link between a case management activity and the provision of a medical service, he said. This 75 percent match rate can only be claimed for medically-related services which are performed by a skilled medical professional. In addition, states have more control over their programs if case management costs are administrative rather than service-related, he said. On the other hand, a state can receive Medicaid payment for a wider scope of activities if case management is considered a service. "Everything a case manager does for a client can be counted as a reimbursable service expense," he explained.

One of the questions raised by state mental health planners at the workshop was how to coordinate case management when a child with severe emotional problems is receiving services from several different agencies. Ohio, which has a mental health case management program targeted to children and adolescents with severe emotional disturbances, has developed a specific strategy for coordinating case management among multiple agencies and systems.

First, according to a July 1988 discussion paper prepared by the Ohio Department of Mental Health (ODMH), the local mental health system should determine what other agencies are providing services, including case management, to a child with severe emotional disturbances. The next step is to develop a case management plan for each child, delineating the case management responsibilities of every agency involved and providing for continuous monitoring and revision of the plan. As a child's needs change, responsibilities will shift, and so "the designation of lead case manager is vital to ensure that someone is ultimately responsible for the coordination of the case," the paper states. In addition, clarifying lead responsibility reduces "duplication of effort and frustration for both the family seeking services and the agencies providing the services," ODMH explained.

Any turf problems that prevent coordination of case management services can be referred to the local "cluster" of youth service agencies, established in communities throughout Ohio to plan and consolidate funding for services to individual children with severe emotional disturbances. If that approach fails to resolve the issue, the Interdepartmental Cluster for Service to Youth, composed of six state-level departments, can step in, the discussion paper says.

Special Education "Related Services"

Although not a mandatory or optional Medicaid service--like the services described above--recently enacted Medicare catastrophic protection legislation gives states further opportunity to expand Medicaid-funded medical services for some emotionally impaired children. The new Medicare law includes a clarification on Medicaid's financial responsibility for certain "related services" provided to handicapped children under the 1975 Education for All Handicapped Children Act (P.L. 94-142). Joe Manes, senior policy analyst, Mental Health Law Project, described the new provision and its potential impact at the CASSP workshop.

Under PL 94-142, handicapped school-age children are entitled to a range of educational and "related services," which must be spelled out in each child's Individualized Education Plan (IEP). The "related services" include speech pathology and audiology, psychological services, physical and occupational therapy, medical counseling, and diagnosis and evaluation services, all of which are allowable under Medicaid.

In several states, including Massachusetts, the Medicaid agency agreed to pay for such services for eligible children. But HCFA denied the claims, ruling that it will not reimburse states for any service in a child's IEP, even if the child is eligible for Medicaid and the service is allowable. The state's education department is the primary payer for such services, HCFA argued. Massachusetts challenged HCFA's decision in court and eventually won. The appeals court concluded that HCFA could not deny payment solely because the services were included in a child's IEP.

The conference report accompanying the new Medicare law further clarified Congress' intent on this issue. While the state education agency has primary responsibility for financing educational services for handicapped children, the report says, the state Medicaid agency is responsible for the cost of the "related services" identified in the IEP of a Medicaid-eligible child if the services are included in the state Medicaid plan.

"This simple clarification will go far to make these services more readily accessible" to handicapped children, Manes said. The potential for Medicaid financing of these services goes even further because of the extension of the special education program to infants and toddlers, under the 1986 Amendments to the Education for All Handicapped Children Act (PL 99-457).[6]

ONGOING STATE PLANNING EFFORTS

In their individual planning sessions, the state delegations went through a process of examining the children's mental health system in their state to determine what elements of the system of care are currently in place, the strengths and sufficiency of each element, and the barriers to or needs for implementing and financing the required level of service for each component. The delegates then looked at the ability of the current Medicaid program to reimburse each of these services.

The delegations next examined each of the Medicaid options reviewed in the previous section to determine its potential for overcoming the barriers

and meeting the needs outlined. They selected strategies and set goals for increasing the use of Medicaid to finance home- and community-based services for children and youth with severe emotional disturbances in their states. Lastly, they outlined initial workplans for reaching these goals.

All ten state delegations chose to explore the EPSDT program because of its ability to furnish a wide variety of screening and treatment services to children while avoiding the budget implications of serving the larger adult population. While most states have had EPSDT programs in place for up to 15 years, few have taken full advantage of its potential. To reach this potential, delegations plan to work with other state agencies, professional organizations, mental health providers, and federal representatives. Florida, for example, is looking at EPSDT as the initial entry point for its system of care and to furnish case management services until a diagnosis is made and a care plan is developed. That is, for Medicaid recipients, EPSDT will be used for the initial assessment component of Florida's comprehensive service system, and the case management component of EPSDT will be used until the child is diagnosed and a permanent case manager is assigned.

Six states expressed interest in beginning to use or increasing the use of targeted case management under Medicaid for coordinating services for children and youth with severe emotional disturbances. Most of these states already use Medicaid case management for specific adult populations. They stressed the need for interagency collaboration since there are a number of agencies in each state providing case management services to children. Therefore, these states will work closely with a variety of agencies at the state and local levels.

Other options singled out by a number of state delegations include rehabilitation services, clinic services, and personal care services. The rehabilitation benefit was particularly popular because service delivery sites are not limited to clinics or their satellites. Clinic services were seen as a good vehicle for moving day treatment services away from hospital settings and for providing care in rural areas where there are no hospital facilities. Two states plan to explore the personal care services option to see if it can be used to fund respite care.

Additional tasks identified in state plans include increasing the training of staff across agencies, using Medicaid to increase therapeutic foster care services, switching some patients from inpatient to outpatient services, and using Medicaid to pay for non-emergency transportation. Most states are developing a multi-faceted strategy to reduce the number of children in

hospitals and residential treatment programs and to increase the availability of mental health services for children in the home and other community settings.

In his review of the workshop, Ira Lourie, M.D., Chief of the Child and Family Support Branch of NIMH, urged states to carefully consider and evaluate each of the Medicaid options discussed in order to determine the potential for increasing availability of children's mental health services in the community. This review is one component of a comprehensive state planning process which is critical to developing a system of care for children and youth that is supported by a range of funding sources. The state planning process should include an examination of those services which are most needed in the community and the funding sources which can best enable the state to provide these needed services. Dr. Lourie emphasized using Medicaid as one part of the state funding system covering a continuum of mental health services for children and youth with severe emotional disturbances.

To assist states in this evaluation and planning process, Appendix C contains a check list for assessing at how well a state's Medicaid program covers each Medicaid option for financing a system of care for children and adolescents with severe emotional disturbances. Chris Koyanagi, Director of Federal Relations for the National Mental Health Association, prepared this list of questions regarding Medicaid coverage options as part of *Operation Help: A Mental Health Advocates Guide to Medicaid.* This information, when combined with the review of Medicaid options discussed in this report, will enable mental health agency staff to work collaboratively with Medicaid agency personnel in the complex area of financing community-based service systems.

One of the positive outcomes of this workshop has been the increased communication between Medicaid and mental health agencies. Dr. Lourie encouraged states to continue this dialogue on increasing community-based mental health services for children and youth with severe emotional disturbances.

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[1] The opinions, conclusions, and strategies of the text are those of the authors and the workshop participants and do not necessarily represent the views of the National Institute of Mental Health, the Prudential Insurance Company of America, and the Robert Wood Johnson Foundation.

[2] Jane Knitzer, *Unclaimed Children*, p. ix.

[3] Specifically, the mental health services component, as described by NIMH, includes case management; day treatment services; early identification, assessment and intervention services; outpatient assessment and treatment; crisis management services; alternative family living; crisis residential hospital services; intensive care services; and prevention services. NIMH's definition of the essential elements of a system of care for severely disturbed children are further described in Chris Koyanagi's *Operation Help: A Mental Health Advocates Guide to Medicaid.* The handbook also lists the Medicaid services that are relevant to each of the essential service system components described by NIMH. This chart is included in Appendix C.

[4] See Fox for details on Medicaid requirements.

[5] The descriptions of the Medicaid service benefits in this report are derived from the speakers' presentations, from question-and-answer sessions, and from various reference documents, including Fox's monograph and Meltzer's paper.

[6] Although no state examples were presented at the workshop, Meltzer's paper described Connecticut's efforts to bill Medicaid for "health-related" developmental and diagnostic services included in a handicapped child's IEP.

APPENDIX A: AGENDA

CASSP Workshop on Medicaid Funding for Mental Health Services for Children and Youth with Severe Emotional Disturbances

*** ALL GENERAL SESSIONS WILL MEET IN THE MARYLAND ROOM ***

AGENDA

WEDNESDAY, SEPTEMBER 14, 1988

8:00 Registration and Continental Breakfast

8:45 Introductions and Review of Workshop Goals

* ***Moderator: Phyllis Magrab***
* ***Ira Lourie***

9:00 A System of Care for Children and Adolescents with Severe Emotional Disturbances

* ***Lenore Behar***

- Identify and describe children and youth with severe emotional disturbances
- Provide framework for a system of care
- Overview of the scope of services currently available
- Gaps in mental health services for children
- How services are typically financed
- Developing a common set of definitions
- What are the problems faced by mental health agencies in using Medicaid?

9:45 Overview of State Medicaid Programs

* ***Richard Jensen***

- Definition of terms
- Flow of dollars from federal to state to local
- Eligibility determination criteria and procedures
- Scope of services
- Providers of services and service delivery sites
- Levels of reimbursement
- Medicaid state plan
- Sources of state match

10:30 Break

10:45 Questions and Discussion

11:15 **STATE DELEGATIONS MEET:** Brainstorming Session

- What elements of a system of care are in place in our state?
- How is the Medicaid program structured in our state?
- Identify specific needs and problems to be addressed

12:15 Lunch

1:30 Options for Medicaid Reimbursement of Home and Community-Based Mental Health Services for Children and Youth: Description and State Examples

- ***Moderator: Harriette Fox***
- ***John Pierce,*** *VT* (waiver and clinic services)
- ***Devon Hardy,*** *FL* (clinic services to rehab services, state match)
- ***Madeline Olson,*** *OR* (waiver and personal care option)
- ***Jim Harrod,*** *ME* (rural and home-based services)
- ***Marilyn Walden/Ron Eggleston,*** *MI* (clinic services & personal care option)
- ***Joe Manes*** (Education for all Handicapped Act)

- Clinic services
- Rehabilitation services
- Waivers
- Personal Care Services
- First dollar coverage issues including P.L. 94-142 and P.L. 99-457
- Other options

3:30 Break

3:45 **STATE DELEGATIONS MEET:** Identify Goals and Strategies

- Review and revise list of specific needs and problems to be addressed
- Establish tentative goals
- Explore options/strategies for achieving goals

5:15 Adjourn

Thursday, September 15, 1988

8:15 Continental Breakfast

8:45 The Potential of Using EPSDT to Provide Mental Health Services to Children and Youth with Severe Emotional Disturbances

- ***Moderator: Kay Johnson***
- ***Fran deFlorio,*** *VT*
- ***Patrick Kanary,*** *OH*

- Overview of EPSDT: pros and cons
- How can EPSDT be used to screen for severe emotional disturbances
- Problems in using the EPSDT program
- Examples of state EPSDT programs

9:30 The Role of Medicaid Case Management in Coordinating Services for Children and Youth with Severe Emotional Disturbances

- ***Moderator: Joanne Griesbach***
- ***Jerry Garber,*** *GA*
- ***Jim Harrod,*** *ME*
- ***Marilyn Walden & Ron Eggleston,*** *MI*
- ***Rick Tulley & Patrick Kanary,*** *OH*

- Overview of case management options: pros and cons
- Applicability to mental health and children
- Examples from state case management systems

10:15 Break

10:30 **STATE DELEGATIONS MEET:** Develop Additional Strategies

- EPSDT in our state and its potential for increasing coverage
- Case management in our state and potential for increased usage
- Refine lists of goals and options/strategies
- Outline additional strategies for improving services to children and youth with severe emotional disturbances

12:00 Lunch

1:15 A Framework for Joint State Planning

- ***Moderator: Connie Dellmuth***
- ***Michael Adams, PA***
- ***Reggie Dunkinson, PA***
- ***David Feinberg, PA***
- ***Sandra Miller, PA***
- ***David Smith, PA***

- Overview of the integration of Medicaid and Mental Health programs
- Setting priorities, defining tasks, and assigning responsibilities
- Steps in the process of integrating or expanding services to maximize Federal reimbursement
- Examples of planning issues: EPSDT, residential treatment facilities, case management, and 2176 waivers

2:15 **STATE DELEGATIONS MEET:** Outline Implementation Plans

- Refine list of specific strategies
- Identify initial steps in process of implementing these strategies
- Develop a timeline for implementation of each strategy

3:15 Break

3:30 Looking Back and Looking Forward: Conclusions and Recommendations

- ***Moderator: Phyllis Magrab***

4:30 Adjourn

APPENDIX B: PARTICIPANTS LIST

CASSP MEDICAID AND MENTAL HEALTH WORKSHOP

September 14 and 15, 1988

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APPENDIX C:

SERVICES FOR CHILDREN AND ADOLESCENTS:

Comprehensive Service System Components And Relevant Medicaid Service(s)

and

Checklist For Services For Children And Adolescents

Source: Koyanagi, Chris. *Operation Help: A Mental Health Advocates Guide to Medicaid.* Alexandria, VA: National Mental Health Association, 1988, pp. 35-40.

Services for Children and Adolescents

Medicaid is the major payor of health care for low-income children. In 1985, more than $5 billion was spent on services used by 11 million Medicaid-eligible children, a significant portion of it for mental health services.

The National Institute of Mental Health listing of the essential components of a system of care for children and adolescents with severe emotional disturbance[3] includes: Mental Health Services (outpatient assessment and treatment, day treatment, alternative family living, crisis management services, case management and intensive care services), Social Services, Educational Services, Health Services, Vocational Services, Recreational Services and Operational Services. The following chart briefly describes these components of a system of care and shows the Medicaid services which are relevant to each. For a detailed description of the Medicaid services, see Chapter 4.

Comprehensive Service System Components	**Relevant Medicaid Service(s)**
A. Mental Health Services	
1. Case Management A set of services provided by a case manager which includes identifying the needs of individual youngsters and assisting them to access services, advocating on their behalf, ensuring that an adequate treatment plan is developed and implemented, reviewing client progress and coordinating services.	Case Management Home & Community-Based Waivers
2. Day Treatment Services A non-residential program of several hours duration, which includes both treatment and educational components.	Rehabilitation Services Home & Community-Based Waivers Clinic Services Partial Hospitalization Services of a General or Psychiatric Hospital
3. Early identification, assessment and intervention services	Early Periodic Screening, Diagnosis and Treatment (EPSDT)
4. Outpatient Assessment and Treatment Mental health services including evaluation, diagnosis and treatment delivered either in a community facility or in the home (including home-based services).	Clinic Services Outpatient Hospital Services Physicians' Services Services of Psychologists and Psychiatric Social Workers Prescribed Drugs Home Health Care Home & Community-Based Waivers
5. Emergency and Crisis Management Services Emergency mental health services available 24 hours a day, seven days a week, delivered in either a community facility or in the home.	Clinic Services Rehabilitation Services General Hospital Services Physicians' Services Services of Psychologists and Psychiatric Social Workers Home Health Care

6. Alternative Family Living Specialized residential care provided in a community-based facility (e.g. therapeutic foster home care, therapeutic residential group care, therapeutic camps, and independent living).	Not a covered service, but some elements may be covered through Home Health Care, Personal Care Services, Rehabilitation, or Home and Community-Based Waivers.
7. Crisis residential hospital services Short-term inpatient hospital care available in times of crises.	Inpatient Psychiatric Hospital Care General Hospital Inpatient Care
8. Intensive Care Services Services not necessarily available in every local community but required to be available within a reasonable time and/or distance to all children and adolescents with severe emotional disturbance. Intensive care services include inpatient hospital treatment and/or treatment at residential treatment centers. Each child placed in such a facility will have an individual treatment plan. The facility may be secure.	Inpatient Psychiatric Hospital Care
9. Prevention Interventions directed at those not yet identified as having emotional problems, especially those children who by virtue of genetic or situational factors are at the highest risk of serious emotional disturbance. Prevention approaches include strengthening self-esteem and problem solving skills, as well as self-help groups and systems change (i.e. modifying systems to increase the likelihood that children will encounter favorable outcomes within the system).	Not specifically a Medicaid service, but could be covered through Medicaid health services Early and Periodic Screening, Diagnosis and Treatment
B. Social Services	Not a Medicaid service
C. Health Services Access to general health care and dental services.	Physician Services General Hospital Dental Care Lab and X-Ray Clinic Services Rural Health Clinics
D. Educational Services	Not a Medicaid service
E. Vocational Services	Not a Medicaid service
F. Recreational Services	Not a Medicaid service
G. Operational Services	
1. Case Management	Case Management (see above)
2. Self-Help and Support Groups	Not a Medicaid service
3. Advocacy	Not a Medicaid service

4. Transportation	Medicaid separately defines transportation and authorizes providers to bill for costs of transportation to essential Medicaid services for clients.
5. Legal services	Not a Medicaid service
6. Volunteer Programs	Not a Medicaid service
7. Respite Care	Not a Medicaid service

This chart clarifies that while Medicaid may be relevant for financing many of the essential services children and adolescents with serious emotional disturbance need, there are other important services which Medicaid cannot finance. Other resources will have to be sought to complete the services package. However, Medicaid can provide substantial support for eight of the services NIMH identifies as needed.

The chart above can identify which Medicaid service categories would finance those components of a system of care to which Medicaid-eligible individuals need better access. Once the Medicaid categories are identified, advocates need to examine the state plan to determine whether Medicaid in fact finances this care appropriately in their state.

Using the information in Chapter 4 (which summarizes what states have done under these different Medicaid categories) and the following Check List, advocates can assess how well a state's Medicaid program encourages an appropriate system of mental health care for children and adolescents with serious emotional disturbance.

As for adults, Medicaid can provide significant reimbursement for many essential services for children and adolescents. In reviewing a state Medicaid plan to determine its impact on children and adolescents with emotional disturbance remember that many children's services are currently covered under the same category as services for adults. It is therefore advisable to review the adult Check List as well as the Check List below. However, there are sufficient differences between the needs of children and adolescents versus adults, to make it advisory to add certain specific references to services for children and adolescents under most state Medicaid service categories.

Since priorities will have to be set in determining which Medicaid services to expand, the following Check List is structured in approximate priority importance (based upon the need for the service among children and adolescents with severe emotional disturbance, current coverage in most states of the service, and effectiveness of the service as Medicaid defines it).

CHECK LIST FOR SERVICES FOR CHILDREN AND ADOLESCENTS

Case Management: For children and adolescents who normally receive services from a variety of agencies such as schools and social welfare, case management is essential. The chart above shows clearly how many different services youngsters may need and suggests the range of agencies involved in providing such care. Medicaid case management services can provide the essential likages to ensure that children and adolescents receive the services they need (See Ch. 4, p.50).

- ☐ Does the state have a case management option?
- ☐ If so, are case management services for children and adolescents with severe emotional disturbance separately described from adult services under this option?
- ☐ Is the range of services covered under case management appropriate for children and adolescents and does it ensure appropriate access to educational and social support as well as specialized treatment services.
- ☐ Are child care agencies as well as other mental health agencies, eligible as providers of case management services?
- ☐ Are case management services under Medicaid coordinated with similar services provided through the schools for those children identified under the Education of the Handicapped Act as needing special education services?
- ☐ Are there limits on the case loads of case managers, and if so, are these appropriate for provision of good care?
- ☐ Does the definition of case management services allow for family conferences as well as coordination among agencies and other case management services?

Early and Periodic Screening, Diagnosis and Treatment: EPSDT enable Medicaid children and adolescents to receive well-child and necessary treatment services much like those obtained by middle class children, and although it does not mandate inclusion of psychological screening, EPSDT's importance as a potential source

of financing for appropriate care for children and adolescents with severe emotional disturbance cannot be underestimated. By expanding coverage under EPSDT rather than under the Medicaid program as a whole, states could offer additional benefits to children and adolescents only, and thus control costs. (See Chapter 4, page 56.)

- ☐ Is there a detailed screening protocol for doctors under EPSDT?
- ☐ Does the state ensure that all eligible children and adolescents are screened for developmental and mental health problems through EPSDT?
- ☐ Is there a mental health component in the list of questions EPSDT providers are expected to answer?
- ☐ Does the state use the EPSDT expanded treatment option to cover mental health services not normally included in the state plan for children and adolescents who are found as the result of a screen under EPSDT to be in need of such services?
- ☐ If not, does the state at least lift the restrictions on amount, duration or scope in its state plan for mental health services found to be needed as a result of an EPSDT screen?
- ☐ Are the schedules for EPSDT screenings in line with the schedule recommended by the American Academy of Pediatrics?
- ☐ Is the EPSDT program run jointly by both Medicaid and the Maternal and Child Health office in the state? If so, does the Maternal and Child Health Office have an interest in expanding mental health screening and would it use its influence with the Medicaid agency to accomplish this?
- ☐ Does the state have adequate means of informing parents of eligible children and adolescents about EPSDT screenings?
- ☐ Is transportation to such screenings readily available?

Clinic Services: Clinics can provide outpatient assessment and mental health therapy as well as other ambulatory treatment to children and adolescents with serious emotional disturbance and their families. (See Chapter 4, page 53.)

- ☐ Does the state have the clinic option?
- ☐ Does the state have separate definitions of qualified clinics for children's agencies as compared with agencies which serve adults?
- ☐ Is the definition of clinic appropriate for inclusion of specialty clinics for infants and young children and of other specialized children's mental health clinics?
- ☐ Does the state mental health authority define eligible children's clinics, or if not, is the state mental health authority satisfied with the definition?
- ☐ Are outpatient mental health clinic services for children and adolescents separately described from adult services?
- ☐ Does the clinic services definition encompass a range of appropriate treatments for children and adolescents, including play therapy, services to improve the developmental functioning of the child—family therapy and services which may be required by a child's special education plan?
- ☐ Does the state place limits on the amount of clinic services available (other than limits based solely on medical and psychological necessity)?
- ☐ Are limits on services for children and adolescents identical to limits on clinic services for adults?
- ☐ Are limits on children's and adolescent's outpatient clinic services appropriate?
- ☐ If limits on the number of days of care per year are established, can these limits be exceeded based on prior authorization?
- ☐ How does the state define physician supervision and can other mental health professionals provide appropriate services, as defined in state licensure laws?
- ☐ Does the state provide a partial hospitalization benefit under the clinic option and/or the hospital outpatient benefit?
- ☐ If so, is the definition of covered day treatment services appropriate for children and adolescents and sufficiently broad to cover the range of services they may need?
- ☐ Are there yearly limits on day treatment services, and if so are they appropriate?

Rehabilitation (Day Treatment) Programs for Children and Adolescents: Day treatment is an important and very under-utilized service for children and adolescents with serious emotional problems. Programs which provide all-day care can be a very effective alternative to residential placements. Medicaid day treatment services for children and adolescents with serious emotional disturbances should be a high priority for children's advocates. (See Chapter 4, page 51.)

- ☐ Does the state cover rehabilitation services under the Medicaid option for "Other Diagnostic, Preventive and Rehabilitative Services?"
- ☐ If so, does the description of such services include appropriate non-medical day treatment services for children and adolescents?
- ☐ Can such services be authorized and furnished by either a physician or other mental health professional?

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- ☐ Can such services be of more than four hours duration per day?
- ☐ If limits on the numbers of day of care per year are established, are they appropriate for good care? Can these limits be exceeded based on prior authorization?
- ☐ Is there coordination between Medicaid day treatment and similar services found to be needed through the child's Individual Education Plan developed under the Education for Handicapped Children Act?

Prescription Drugs: For some children and adolescents, coverage of prescription medications is a most important benefit. (See Chapter 4, page 57.)

- ☐ Does the state have this optional benefit?
- ☐ Are there any limits which would restrict access to appropriate medications for children and adolescents with serious emotional disturbance?
- ☐ Does the state have limits on the number of prescriptions which can be covered in a certain time period, or the number of refills or the quantity in each prescription? If so, are such limits reasonable for those children and adolescents who need to take medications for emotional problems on a regular basis?
- ☐ Does the state require co-payments from the family for prescriptions? If so, are these a barrier for low-income people to obtain necessary medications?

Physician Services: Children and adolescents with serious emotional disturbance often will need the services of a physician, preferably one specially trained in child and adolescent mental health. (See Chapter 4, page 57.)

- ☐ Does the state limit services of child and adolescent psychiatrists, either separately or as part of a broader psychiatrist limit? Is it possible to have a higher limit on services provided to children and adolescents?
- ☐ Are the limits on child and adolescent psychiatric care appropriate?
- ☐ Can limits be exceeded with prior authorization?
- ☐ If prior authorization is required, does the state ensure that it does not act as a barrier to services for those who need on-going physician care? For example, how quickly can such authorizations be obtained?
- ☐ Does the state ensure that in addition to visiting a private practicing physician, Medicaid-eligible individuals can obtain access to physician services through child care clinics?

Services of Other Mental Health Practitioners: Many children and adolescents who need assessment and therapy can be helped by the services of a psychologist or psychiatric social worker. (See Chapter 4, page 58.)

- ☐ Does the state cover child and adolescent psychologists?
- ☐ Does the state cover psychiatric social worker services for children and adolescents?
- ☐ If covered, are limits the same as for physicians?
- ☐ Are psychologists covered not only for testing but also to provide mental health services as permitted under state licensure?
- ☐ If not full coverage, does the state cover psychologists and social workers in clinics or in remote rural areas where alternative services are not available?

Hospital Outpatient: Under Medicaid rules, hospital outpatient departments can provide the same assessment and mental health therapy and other treatments to children and adolescents and their families as clinics. However, the availability of child and adolescent mental health services through general hospitals is quite limited in some areas and this service should normally be seen as a back-up to clinic services. (See Chapter 4, page 55.)

- ☐ Is hospital outpatient mental health care available for Medicaid-eligible children and adolescents in the state?
- ☐ Does the state place the same limits on general hospital outpatient care as it does on other outpatient mental health services, such as clinic services?
- ☐ Does the state set different limits for child and adolescent outpatient hospital services than for adults? Are the limits appropriate?
- ☐ If the state covers psychiatric hospitals, as well as general hospitals, does it set different and more generous (or less generous) limits for care furnished in general hospitals?

Inpatient Psychiatric Hospital Services: For children and adolescents who need inpatient treatment, services in a qualified psychiatric facility may be advisable. (See Chapter 4, page 60.)

- ☐ Does the state cover the optional service of psychiatric hospital care for children and adolescents?
- ☐ If so, is care in state and county mental hospitals and in general hospitals covered without limit?
- ☐ If limits are imposed, are they related to the median length of stay for children and adolescents in various psychiatric facilities? (36 days in a private psychiatric hospital, 54 days in a state hospital and between three months to two years in a residential treatment center)*
- ☐ If limits are low, can they be exceeded, based upon medical and/or psychological necessity?
- ☐ Are there requirements that children and adolescents can only be admitted when alternative community care and treatment cannot meet their needs?

- ☐ Does the state ensure coordination between hospital inpatient care and community outpatient services? For example, does the definition of inpatient care include stipulations for discharge planning which will ensure appropriate coordination between the hospital and the community programs (including school) to which the child or adolescent will return?

Other Inpatient Hospital Services: Stabilization of acute conditions in a community general hospital can be an important service and is covered under the inpatient general hospital benefit (mandatory). For those states that do not have the optional Psychiatric Hospital benefit, this will be the only inpatient psychiatric care available under Medicaid for children and adolescents. (See Chapter 4, page 59.)

- ☐ Does the state limit psychiatric coverage in general hospitals?
- ☐ If so, are these limits sufficient to at least cover the average length of stay of children and adolescents in these facilities (14 days)?[5]
- ☐ Can limits be exceeded with prior authorization, based upon medical necessity?
- ☐ Does the state coordinate services between general hospitals and specialized psychiatric hospitals if covered under the state plan?

Home Health Services: Services in the home, for both the client and the family, are an important part of a continuum of care for children and adolescents with serious emotional disturbance. (See Chapter 4, page 58.)

- ☐ Does the state cover the optional home health care benefit?
- ☐ If so, does it provide coverage for mental health home care services for children and adolescents?
- ☐ Are such services covered at least when furnished through child care or other qualified clinics?
- ☐ Does the definition of home health care coverage specifically exclude services needed by children and adolescents with serious emotional disturbance?
- ☐ Are children and adolescents who are nonetheless homebound due to some other disability eligible for mental health intervention services (such youngsters could be at high risk of emotional problems)?

Transportation: As for adults, expenses for transportation and other related travel expenses necessary to secure medical examinations and treatment for a Medicaid eligible child or adolescent are covered Medicaid services. (See Chapter 4, page 59.)

- ☐ Does the state ensure that expenses for transportation and other related travel expenses necessary to secure health care are reimbursable?
- ☐ Are families, as well as provider agencies, aware and fully informed by the state as to the availability of this coverage?

Home and Community-Based Care Waiver: Requesting a waiver to expand services for children and adolescents may not be necessary and will be hard to accomplish. It is easier, although more expensive, for states to expand services by creative use of the state plan. (See Chapter 4, page 62.) Advocates who are nonetheless interested in a waiver, should consider the following factors:

- ☐ Does the state need a waiver to expand mental health services to children and adolescents, or could the same expansion be accomplished by amending the state plan using regular Medicaid services?
- ☐ Does the state cover the optional inpatient psychiatric hospital service? (Without this option, the state will find it hard to show off-setting savings in institutional Medicaid costs to be used for the home and community-based care services.)
- ☐ Does the state need the waiver to move certain categories of children and adolescents out of institutional placement (or to prevent institutional placement) and to expand community services only for this defined group of youngsters?
- ☐ Can the state provide measurable criteria to conduct individual assessments of children's imminent risk of hospitalization (as will be required by HCFA)?
- ☐ Can the state show cost-effectiveness by demonstrating conclusively that community-based care would be less costly to the Medicaid program by diverting children from inpatient care that is currently covered under the state plan?

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